Bureau of Health Care Quality & Compliance

AND DIAN OF CODDECTION		(X1) PROVIDER/SUPPLIER/O	BER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS3170AGC		B. WING		06/1:	2/2009	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•		
FELIS CA	RE HOME			HERWOOD A DN, NV 89015				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
Y 000	Initial Comments			Y 000				
	by the Health Division prohibiting any crimin actions or other claim available to any party state, or local laws.	clusions of any investign shall not be construed all or civil investigations s for relief that may be under applicable feder	l as s, ral,					
	This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 6/11/09 and completed on 6/12/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.							
	The facility is licensed for 7 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 4. Four resident files were reviewed and 2 employee files were reviewed. The facility received a grade of D.		e of					
	Complaint #22113 wa Y 272, Y 274, Y 755,	as substantiated. See <sup>-</sup> Y 858	Гags					
	The following deficier	ncies were identified:						
Y 050 SS=F	449.194(1) Administra Responsibilities-Over			Y 050				
	1. Provide oversight members of the staff to ensure that resider and protective superv in compliance with the	a residential facility sha and direction for the of the facility as necess its receive needed servision and that the facility requirements of NAC inclusive, and chapter	sary vices ty is					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 08/03/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3170AGC 06/12/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1042 FEATHERWOOD AVE FELIS CARE HOME** HENDERSON, NV 89015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 050 Continued From page 1 Y 050 This Regulation is not met as evidenced by: Based on interview, record review and observation on 6/11 and 6/12/09, the administrator failed to provide oversight and direction to the staff to ensure 4 of 4 residents receive the needed services and protective supervision they required. Please refer to Tags Y 72, Y105, Y 106, Y 152, Y 274, Y 276, Y 755, Y 859, Y 878, Y 898, Y 936. Severity: 2 Scope: 3 Y 053 Y 053 449.194(4) Administrator's SS=F Responsibilities-Complete Rec NAC 449.194 The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on record review, observation and interview on 6/11 and 6/12/09, the administrator failed to keep the records of the facility complete

and accurate.

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  - 06/12/2009		
NAME OF PR	ROVIDER OR SUPPLIER	NVS3170AGC	STREET ADD	<b></b> RESS, CITY, STA	TE, ZIP CODE	06/1	12/2009	
FELIS CARE HOME		1	HERWOOD A' ON, NV 89015					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Y 053	Please refer to Tags 878, Y 898 and Y 936	Y72, Y 195, Y 106, Y856. ficiency from the 11/21.		Y 053				
Y 072 SS=F	Training  NAC 449.196 3. If a caregiver assist facility in the administ including, without liming medication or dietary must:  (a) Receive, in additing pursuant to NRS 449 training in the manage caregiver must received 3 years and provided to satisfactory evidence and his attendance assists.	ests a resident of a resident ration of any medicatic itation, an over-the-coursupplement, the caregon to the training require. 037, at least 3 hours of the training at least 6 the residential facility were of the content of the training; and lears, pass an examinat gement of medication.	on, inter giver red of The every eith raining	Y 072				
	Based on record revi failed to ensure that 2 completed the require	ed three hour medication er training every three y	lity					

AND DIAM OF CODDECTION IN /		(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		NVS3170AGC		B. WING		06/1	2/2009		
EELIS CADE HOME			1042 FEATI	STREET ADDRESS, CITY, STATE, ZIP CODE  1042 FEATHERWOOD AVE HENDERSON, NV 89015					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETE DATE		
Y 072	Continued From pag	e 3		Y 072					
	This was a repeat de State Licensure surv	eficiency from the 11/21. ey.	/08						
	Severity: 2 Scope:	3							
Y 105 SS=F	449.200(1)(f) Person	nel File - Background C	Check	Y 105					
	a separate personne member of the staff of	se provided in subsection of file must be kept for eaction of a facility and must inc diance with NRS 449.17	ach clude:						
	Based on record revi facility failed to ensur	ot met as evidenced by iew on 6/11 and 6/12/09 re 2 of 2 caregivers met equirements (Employee	), the						
	This was a repeat de State Licensure surv	eficiency from the 11/21.	/08						
	Severity: 2 Scope:	3							
Y 106 SS=F	449.200(2)(a) Person	nnel File - 1st aid & CPF	٦	Y 106					
	information required	ust include, in addition to pursuant to subsection ng that the caregiver is perform first aid and							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	NVS3170AGC			B. WING		06/12/2009	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
FELIS CA	RE HOME			HERWOOD A' ON, NV 89015			
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Y 106	This Regulation is no Based on record review	ot met as evidenced by: ew on 6/11/09, the facil I of 2 caregivers were I cardiopulmonary (ree #2). ficiency from the sure survey.		Y 106			
Y 151 SS=F	NAC 449.204  1. A residential facility (b) Maintain a contract against liability to thin appropriate for the premployees, volunteer  This Regulation is not Based on observation the facility failed to eninsured.  This is a repeat deficit State Licensure Survey.	y shall: ct of insurance for prote d persons in amounts otection of residents, rs and visitors to the fac ot met as evidenced by: n and interview on 6/11 nsure the facility was	cility. : : /09,	Y 151			
Y 152 SS=C	449.204(2) Insurance			Y 152			

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on observation and interview on 6/11/09, the facility failed to ensure a planned, dated and

Scope: 3

posted menu was utilized.

Severity: 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS3170AGC		B. WING		06/12	2/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
FELIS CAI	RE HOME		1042 FEATH HENDERSOI	IERWOOD A' N, NV 89015			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
Y 276	Continued From page	e 6		Y 276			
Y 276 SS=F	449.2175(7) Nutrition	and Service of Food		Y 276			
	and prepared with reg preferences and religi three meals a day mu intervals. The times a served must be poste may elapse between breakfast the next day available between me	suitable for the resident gard for individual ious requirements. At I ist be served at regula	east r ours g and de				
Y 755 SS=D	Based on observation the facility failed to prosnacks between meal Severity: 2 So	ot met as evidenced by: a and interview on 6/11/ ovide nutritious meals a ls for 4 of 4 residents.  cope: 3  wel & Bladder Incontine	/09, and	Y 755			
	facility with a resident condition of bowel or ensure that: (a) If the resident can toileting, he is assiste bathroom at regular ir (b) The resident is che	ployed by a residential who has a manageable bladder incontinence significant benefit from scheduled dor reminded to go to netervals.  ecked during those per be incontinent, including	hall d the iods				

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NVS3170AGC

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1042 FEATHERWOOD AVE

NAME OF PROVIDER OR SUPPLIER  FELIS CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE						
			HERWOOD A' DN, NV 89015					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
Y 755	Continued From page 7  during the night; (c) The resident is kept clean and dry; (d) Retraining programs are designed by a medical professional with training and exper in the care of persons with bowel or bladder dysfunction; (e) The retraining programs established for a resident are followed; and (f) Privacy is afforded to the resident when obeing provided.	a	Y 755					
	This Regulation is not met as evidenced by Based on record review and interview on 6/ the facility failed to provide assistance to the bathroom and to keep Resident #1 clean an Severity: 2 Scope: 1  449.274(4)(c) Medical Care / Records	11/09,	Y 858					
SS=D	NAC 449.274 4. the facility shall ensure that appropriate medical care is provided to the resident by: (c) A medical professional.							
	This Regulation is not met as evidenced by Based on record review and interview on 6/2 and 6/12/09, the facility failed to provide medicare for 1 of 4 residents by not providing	11/09						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING	<u> </u>	20/40/2020	
		NVS3170AGC	CTDEET ADD			06/1	2/2009
NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, STA			
FELIS CA	RE HOME			HERWOOD A DN, NV 89015			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
Y 858	Continued From page	e 8		Y 858			
	transportation to dialy Resident #2.	sis treatment on 6/1/09	o for				
	Severity: 2	Scope: 1					
Y 859 SS=E	449.274(5) Periodic Physical examination of a resident			Y 859			
	NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.						
	Based on record revie failed to ensure that 2	ot met as evidenced by: ew on 6/11/09, the facil 2 of 4 residents receive assion (Resident #2 and	ity ed a				
	This was a repeat des State Licensure Surve	ficiency from th 11/21/0 ey.	8				
	Severity: 2 Scope: 2	2					
Y 878 SS=F	449.2742(6)(a)(1) Me	dication / Change orde	er	Y 878			
	NAC 449.2742 6. Except as otherwis	se provided in this					

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(4) Instructions for administering the medication to the resident that reflect the current order or prescription of the resident's physician.

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(Resident #2 and #4) which affected all residents.

This was a repeat deficiency from the 11/21/08

State Licensure survey.

Severity: 2 Scope: 3